303 N. Church Street
Murfreesboro, TN 37130

RUTHERFORD COUNTY GOVERNMENT

"ON-THE-JOB INJURY" *EMPLOYEE INJURY STATEMENT*

Phone (615) 898-7715
Fax (615) 867-4602

Information: This form must be completed by the injured employee at the time of any incident and sent with the OJI Claim Report. You are hereby instructed that all medical attention received for this injury must be with the immediate permission from the RC Risk Management Department. Non-authorized treatment will void any future OJI benefits for this specific claim.
PLEASE NOTE: Completion of an On-the-Job Injury Statement does not automatically ensure OJI program coverage. Inactivity of 30 consecutive days of an OJI filed claim will mean cessation of benefits.

As is allowed by T.C.A. 50-6-106, Rutherford County (RC) has opted to withdraw from the Tennessee Workers' Compensation Act, and instead has chosen to implement an On-The-Job Injury Program administered by the Rutherford County Risk Management Department.

Employee Name
Social Security No
Supervisor
Time employee began work on the date of injury:

Date of Injury:
Work Location
Injury Location
Time work shift scheduled to end:

What Job were you doing when the injury /illness occur?

Is this the first time you reported this injury/illness? ☐ Yes ☐ No

If "No" when did you first report it?

To whom did you first report it?

Was there anyone around at the time of the Injury? ☐ Yes ☐ No
Name

What safety equipment were you supposed to be wearing?

Were you wearing the safety equipment? If not why not?
☐ Yes ☐ No

Were any safety or work rules being violated at the time of the injury?
☐ Yes ☐ No If so what were they?

Were you performing your job as instructed?
☐ Yes ☐ No If not what changes were made and why?

Was any machine or other piece of equipment involved with your injury?
☐ Yes ☐ No If "yes" please explain in specifics:

Have you ever had a similar injury to the same or similar part of the body?
☐ Yes ☐ No If "yes" describe when and where.

In your own words, describe what happened:

Employee Only: I, (print employee name) _____ , understand all OJI Claims are investigated by the Risk Managemenr Department. Completion of an Employee Injury Statement or attempting to file an OJI Claim does not automatically guarantee acceptance of the individual claim. Therefore, after a full investigation of my OJI Claim, my claim may be non-compensable although I may have already seen an OJI Physician with OJI office approval. If this occurs, bills prior to the investigation will be paid in full by the Risk Management Department and I understand that I will be responsible for any further treatment or medication. I also understand that any unauthorized medical treatment will be my sole responsibility, as there is no coverage provided when this occurs. I also hereby authorize the release of my protected health information from any and all health care providers, their employees, and agents and direct them to release or disclose to RC Insurance Department (address above) my complete medical record regardless of stated areas of injury. I waiver my right to confidentiality of these records for the purpose of an on-the-job injury. These records may be used by RC in making a determination as to my eligibility for benefits under the On-the-Job Injury program. Unless otherwise stated, this authorization expires 360 days from the date of execution. Making a false or fraudulent claim is an immediate ground for termination from RC.

Employee Signature: _____ Date: _____

OJI EMPLOYEE INJURY STATEMENT

Form revised Feb 2012